ATTACHMENT II
Statewide Requirements

1.0 Claims Processing

1.1 Billing and Claims Processing

The LME shall honor provider billings as long as they are filed in time to meet DHHS billing requirements. For Medicaid services billed through the LME, billings will be honored for up to twelve (12) months from the date of service. For services covered by funds allocated by the DMH/DD/SAS, billings shall be honored in accordance with the IPRS timely filing provisions.

If the provider bills within sixty (60) days of providing a service, the LME will pay claims in accordance with the Division of Mental Health, Developmental Disabilities and Substance Abuse prompt pay requirements set forth as follows: within eighteen (18) calendar days after the LME receives a claim from a provider, the LME shall either (a) approve payment of the claim, (b) deny payment of the claim, or (c) determine that additional information is required for making an approval or denial. If the LME approves payment, the claim shall be paid within (30) calendar days after making approval.

The LME shall disallow claims in the event and to the extent the claim is incomplete, does not conform to the applicable service authorization, or is otherwise incorrect. Any claim disallowed shall be returned to the provider with an explanation for the disallowance. The LME shall allow providers to re-submit a disallowed billing for re-consideration, so long as the re-submission occurs within the general claims filing timeframes outlined above. The LME shall cooperate with its contract providers in the prompt reconciliation of disallowed billings.

The LME shall not pay claims submitted after the time period allowed by DHHS billing requirements.

All payments for services to providers shall be provisional and subject to review and audit for their conformity with DHHS requirements and those of any applicable subcontract.

The LME claims payment system, as well as its prior authorization and concurrent review process shall minimize the likelihood of having to recoup already paid claims. The DHHS shall be notified within thirty (30) days of any recoupment of $50,000 or more per provider within a contract year.

The LME and its providers shall not charge or receive any payment from an eligible Medicaid person for covered services except for co-payments and sums payable by third party payers under coordination of benefits provisions.

1.2 Reimbursement

The LME shall work with its providers to pursue all applicable first and third party payments for services in order to maximize the usage of public resources. In the event that a consumer has third party coverage or is determined to be able to pay any portion of the cost of services in accordance with the LME's sliding fee scale (non-Medicaid covered individuals and services only), the LME shall coordinate benefits so that costs for services otherwise payable by DHHS are avoided or recovered from a liable first or third party payer. The LME's claims system shall include appropriate edits for coordination of benefits and third party liability.

The LME may retain any first (patient fees) or third party revenue obtained for consumers served through the LME if all of the following conditions exist:

(1) Total collections received do not exceed the total amount of the LME's financial liability for all persons served.
(2) State or federal law does not require such recovery.

The LME shall obtain, or require its contracted providers to obtain, all relevant payer information from each consumer to be served, his or her guardian and/or family. This information should be collected at the consumer's first encounter with the LME or its contract provider, but no later than the submission of the first claim for service. The LME shall provide available information to each provider involved with the consumer and require the provider to collect the remaining information, if applicable.

2.0 Provider Relations and Support

2.1 Qualified Provider Community Development Plan

The LME shall maintain a current provider list and service array distribution. All Medicaid providers enrolled and in good standing with the Division of Medical Assistance shall be deemed to be a part of the LME's provider community.

The Provider Community Development plan shall be reviewed and updated on an annual basis each October.

2.2 Contracting for Service Delivery

The LME shall include in its contracts for service delivery a requirement that all activities carried out by contracted providers conform to the provisions of this Contract and comply with the applicable provisions of federal and state laws, regulations and policies.

All provider contracts shall be in writing. The LME shall maintain a fully executed original of all contracts that shall be accessible to the Department within two working days of request. The LME may not include covenant-not-to-compete requirements in its contracted provider agreements. The LME may not contract with any individual or entity that has been debarred, suspended or otherwise lawfully prohibited from participation in any federal or state government procurement activity.

2.3 Conflict of Interest

The LME, including its Board of Directors, advisory committees, employees, volunteers and contractors shall not be a party to any clinical or administrative activity or decision that places personal gain or interest, or that of a related party, in conflict with the health, safety, security or well-being of individuals receiving services under this contract.

3.0 Access, Screening, Triage and Referral

3.1 Single Entry for State Operated Institutions

A single entry mechanism shall be in place for admission to and discharge from state operated institutions.

The LME shall maintain a specific contractual relationship with State operated institutions that are responsible for serving consumers from their geographic area. The LME shall comply with the DHHS bed-day allocation plan, including requirements for overuse charges if the LME's utilization exceeds the bed day allocation.

The LME Director shall serve as the Division Director's designee in approving admission to State psychiatric hospitals in accordance with G. S. 122C-261(f)(4). In so doing, the LME Director shall ensure every effort has been made to identify an appropriate alternative treatment location prior to approving the admission to the State psychiatric hospital.

3.2 Access Line

The LME shall provide or subcontract for an Access line that is staffed 24/7/365 with live, trained personnel, TTY capable for persons who have a hearing impairment, and foreign language interpretation at no cost to the individuals requiring assistance. Accommodations shall also be made for cultural and demographic differences, visual impairments, augmentive communication, and mobility or other handicap accessibility to the LME and providers. The Access line shall be toll-free for all persons in the LME's catchment area.

3.3 Choice

A consumer's choice of provider, from among enrolled providers, shall be honored by the LME, subject to medical necessity and utilization review criteria and, for State and State-allocated funded services and consumers, the LME's provider subcontracting policies and procedures.

3.4 Cross Area Service Programs (CASPs)

The Division of Mental Health, Developmental Disabilities and Substance Abuse Services allocates some funds to designated LMEs to fund a specific provider or service to offer services to a number of catchment areas. These allocations are known as Cross Area Service Program (CASP) allocations. CASP allocations will be clearly identified in the Continuation Allocation Letter.

Certain CASP funds have been designated as "consumer CASPs," meaning that services must be authorized on an individual consumer basis. At the beginning of each fiscal year, the LMEs sharing consumer CASP funds shall agree on a utilization plan for the funds. The LME to which the funds were allocated shall manage the funds and contract with the provider to provide services to consumers from all participating LMEs. Services for all consumers in the catchment area served by the CASP program shall be authorized by the contracting LME. The CASP provider will bill the contracting LME for all services authorized under the contract for all consumers in the catchment area served by the CASP.

4.0 Service Management

Subcontracting for the actual process of Utilization Review for Medicaid-covered services requires prior written approval from DHHS.

4.1 Continuum of Service

The LME shall ensure that a continuum of services consistent with the State Plan and Service Definitions is available to meet the needs of consumers. All service definitions, unless explicitly stated otherwise, refer to developmental disabilities, substance abuse/dependence and mental health services and populations.

4.2 Notice of Service Denial, Suspension, Reduction or Termination

The LME shall comply with the following whenever covered services are denied, reduced, suspended or terminated:

(1) The LME shall provide notices in accordance with DHHS policy and procedures, using the forms prescribed by DHHS for consumers, if applicable.
(2) The LME shall follow appropriate treatment protocols when denying, reducing, suspending or terminating covered services.
(3) The notice prescribed by DHHS shall be used to provide consumers prior written notice of a reduction, suspension or termination of a service.
(4) When a service is subject to prior authorization, the LME shall comply with all notice, appeal and continuation of benefits requirements specified by State and federal law and regulations.

4.3 Crisis Services

The LME shall maintain a 24-hour, seven day a week crisis response service. Crisis response shall include telephone and face to face capability. Crisis phone response shall include triage and referral to appropriate face to face crisis providers and shall be initiated within one hour. Crisis services do not require prior authorization but shall be delivered in compliance with LME policies and procedures. Crisis services shall be designed for prevention, intervention and resolution, not merely triage and transfer, and shall be provided in the least restrictive setting possible, consistent with individual and family need and community safety.

4.4 Children's Services Memorandum of Agreement

The DHHS has developed Memorandum of Agreement, which envisions the development of a comprehensive, coordinated system of care for children. Parties to this MOA include the DHHS, Department of Juvenile Justice and Delinquency Prevention, Department of Public Instruction and the Administrative Office of the Courts. Under the MOA, various interagency projects and systems are established. The LME is required to participate in MOA activities and adhere to MOA initiatives.

5.0 Consumer Affairs and Services (January 1, 2005)

The LME shall have a policy and written procedures that describe its customer affairs and services function. The LME's organizational structure shall include a clear separation of the Consumer Services functions from Utilization Review, Finance and Provider Services to ensure appropriate safeguards relevant to complaints, disputes, appeals and grievances. Staff assigned to investigate complaints and alleged rights violations shall not participate if prior activities in the same case could compromise the investigation.